TRRx Request for Proposals Questions and Answers
5/2/03

NOTE: This set of Questions and Answers, originally posted April 22, 2003 and updated April 30, 2003 to provide responses to questions 229, 230, 231, 235, 238, and 241, is further updated to expand the response to 235. All other responses remain unchanged.

Question 201. A significant number of questions regarding the functions of PDTS, DEERS, CDCF, and, other interfaces have been asked to date. It is clear to this interested offeror that these interfaces (or, even single interface to PDTS) is a significant development effort to undertake. Will the Government consider a separate CLIN under a Time and Materials arrangement to pay for the Contractor's expenses of developing the interfaces?

Response 201. No. The only interface the contractor is required to develop is with PDTS in accordance with the PDTS ICD at Section J, Attachment 4.

Question 202. The PDTS ICD document is a "draft" and, a later version is now available. Would the Government please cease changes to the document as soon as possible so this Offeror can price the changes required for inclusion in our offer?

Response 202. The latest revision was to correct information based on the forthcoming amendment. The only future changes anticipated prior to award will be to correct errors.

Question 203. Will the Government please explain what real time compliance with MCPF pricing means? Could the Government be more specific of the format and content of transactions "expected from Contractor's system to PDTS", and, "returned from PDTS to Contractor's system"?

Response 203. MCPF pricing does not play a role in this contract and all references to MCPF pricing was removed from the PDTS ICD in the latest update to the document. The format and content of both the claims submission and the response transactions are well documented in the PDTS ICD which conforms to NCPDP 5.1 requirements.

Question 204. Prior Authorizations -- can the Government please provide a clearer process flow for P/As from Contractor's system to PDTS, from MTF systems to PDTS, and, from TMOP to PDTS? SelectRx is mentioned in the minutes from the Bidder's Conference. What is SelectRx? And, what function(s) does SelectRx serve?

Response 204. SelectRx is a proprietary software program that functions as a front end GUI for PDTS. The program is used to view patient profiles, previous transaction detail, perform authorized overrides for vacation supplies, lost medications, etc, enter and document prior authorizations and medical necessities, and enter patient level overrides. DoD will provide the Contractor with the software program and the training necessary to use the software. All prior authorizations will be stored centrally as each point of service processes the required paper work to perform that function. As a result a claim that originates from another point of service that in the past would have required a prior authorization to be performed will now return a paid claims response from PDTS thus

eliminating the necessity for all points of service to perform redundant prior authorizations.

Question 205. As stated previously, PDTS appears to be changing and these changes could provide the incumbent contractor supporting PDTS with an unfair advantage. How will the Government ensure that the current contractor does not have an unfair competitive advantage for TRRx?

Response 205. First, it is an accepted constant in Government contracting that incumbent contractors may have advantages as a result of their incumbency. Secondly, the contractor's responsibility is to transmit prescription data to PDTS, a task that the Government believes is within the norms of commercial data accumulation and reporting. Therefore, the Government does not believe any significant advantage accrues to any current incumbent contractor.

Question 206. There is a requirement for the TRRx Contractor to support transferring calls to the PDTS Customer Support Services Center. Can the Government provide an estimate of the number of these transfer calls we can anticipate?

Response 206. No, this information is not available to the Government. This will in large part depend on the clarity of the marketing and education materials provided in the contractor's initial mailing, and on the training provided to the contractor's beneficiary service staff.

Question 207. Is the PDTS Customer Support Services Center operated solely by Government/DoD staff? If not, and, if there is a Contractor(s) involved, this offeror feels the incumbent contractor(s) would have an unfair advantage of understanding how PDTS works, and, the estimates for call volumes. How will the Government ensure no competitive advantage exists for any such contractor(s)?

Response 207. The PDTS Customer Service Center is operated by a mix of Government and contracted staff. Given the significantly different nature of the current retail pharmacy program and the program that will become effective under TRRx, the number of calls currently received by the PDTS Customer Service Center is not relevant to what will be received under TRRx.

Question 208. Section G1.1.4 of the RFP does not specify how often checks need to be generated. However, TOM Chapter 1 paragraph 1.6 indicates that claims processing cycles must be transmitted not less than three times every seven calendar days. Under the MCSC contracts this was interpreted to mean that checks must be generated at least twice per week. Generally, the industry standard is to pay the pharmacies twice a month. Under the TRRx contract would this payment cycle be permissible or would the referenced TOM section preclude the contractor from doing this?

Response 208. Payment cycles by the contractor to its network pharmacies shall be in accordance with the contractor's normal commercial practices. The Government and the

contractor will establish actual payment cycles following award. As a reminder the TOM does not apply to the TRRx solicitation.

Question 209. Since there will be only one retail pharmacy contractor and therefore only one pharmacy system with access to PDTS, how will non-network electronic claims submitters get claims to the contractor?

Response 209. They will have to establish a relationship with the contractor to submit nonnetwork claims electronically. This may present an opportunity for the contractor to bring the pharmacy into the network.

Question 210. In the response to question 58 you indicate that claims history will be accessible using SelectRx. Will beneficiaries be able to view claims history using Select Rx?

Response 210. No.

Question 211. Reference C.9 "except where a beneficiary is covered by a state Medicaid plan, in which case TRICARE is primary": Under the current MCSC contracts, State Agencies (Medicaid) are permitted to bill TRICARE (TRM Chapter 1, Section 21) for reimbursement after they have interacted with the retail pharmacies. Will the State Agencies continue to submit the pharmaceutical portion of the claims to the MCSC contractor? If the answer is yes was this volume included in the volumes provided in the RFP?

Response 211. No. State Medicaid claims will be processed and reimbursed through TRRx.

Question 212. If the contractor receives a DD2642 claim form that has multiple receipts attached should the contractor process this as a single paper claim or as multiple paper claims? If the answer is process as a single paper claim, please confirm that the paper claim volumes provided on schedule B are based on this process.

Response 212. This issue has been clarified in Amendment 0002 and the Section B volume estimates have been revised. The volume estimates in Section B reflect prescriptions and the contractor will be paid an administrative fee for each prescription processed on paper claims. A separate TED will be generated for each prescription. If a Prior Authorization or Medical Necessity review is required for a specific prescription, it will be included with the TED for that prescription.

Question 213. Regarding question 69 in which TMA was asked which non-English speaking languages need to be provided, the government's response stated the contractor shall make provisions to accommodate any beneficiary who calls. This means that the contractor would need to have staff that could speak almost any language. This is an unrealistic expectation considering the vast number of languages that are spoken and the

few times that they may be encountered. Can the government provide more information regarding this requirement?

Response 213. As one option, the Government understands that various translation services are available that an offeror may consider.

Question 214. The response to question 50 states that only one DD250 is required at the end of each option period to verify acceptance of all claims processed in the option `period. Monthly a DD250 may be submitted for Prior Authorization, and Medical Necessity Determination. Section G.2.1 states that PDTS will generate a TED record for each prescription filled and for each Prior Authorization review and for each Medical Necessity Determination completed. Please clarify if the contractor will be reimbursed for Prior Authorizations and Medical Necessity Determinations upon acceptance of the TED record similar to acceptance of TED records for prescriptions, or will the contractor only be reimbursed upon the submission of a monthly DD250? If the answer is that the contractor will be reimbursed for Prior Authorizations and Medical Necessity Determinations similar to the reimbursement for prescriptions, can a DD250 be submitted at the end of each option period instead of monthly for Prior Authorizations and Medical Necessity Determinations?

Response 214. You are correct. To clarify, prescription transactions, prior authorization transactions and medical necessity review transaction will be accepted and paid through PDTS and TED records. A single DD 250 at the end of each option period may be submitted for each category. The contractor may consolidate all covered line items on a single DD 250 at its option.

Question 215. How many transactions will be required between the contractor and PDTS to process a claim to completion? Will there be one transaction to determine eligibility, followed by a second transaction to check DUR, followed by a third transaction to indicate the script has actually been filled, or will all of the previously mentioned items be handled by a single transaction?

Response 215. The previously mentioned items can be handled by a single transaction. An E-1 enhancement using NCPDP standard formats has been added to the program. This E-1 transaction allows the Contractor to check eligibility only should the need arise.

Question 216. In the government's response to question 12, they stated that the contractor did not need to comply with TOM. Please clarify how the offeror is to respond? Also please clarify what other parts of TOM and other policies the offeror does not need to consider in preparing their response or administering this contract.

Response 216. The TOM is not a part of this solicitation. Offerors shall comply with the instructions provided in the RFP in developing their proposals.

Question 217. The RFP states that there are approximately 8.7 million eligibles. Does this number include Medicare Dual Eligibles? If the answer is no, what is the number of

total eligibles? Also, if the answer is no, do all the statistics provided including the number of current utilizers and drug utilization consider these eligibles?

Response 217. The number of 8.7 million eligible beneficiaries includes all eligible beneficiaries.

Question 218. In the government's response to question 32, they stated that the contractor needs to have benefit cards for approximately 8.7 eligibles, but initially only need to provide cards to the 2.5 million active users. Assuming the contractor would not need to initially provide cards to all 8.7 million eligibles can the government provide an estimate regarding the number of cards that need to be purchased initially and when additional cards for the 8.7 million eligibles would need to be made available over the life of the contract.

Response 218. No. The contractor shall ensure that sufficient cards are available to support the population.

Question 219. For the Oral presentation can the offeror have one or two slides to introduce those who will be making the presentation and provide an overall introduction without having these slides count as part of the 50 slide limitation?

Response 219. The offeror may include whatever information it considers pertinent up to a maximum of 50 slides, introductory slides are included in the maximum count of 50 slides.

Question 220. Section L.6 page 47 – The RFP states the government will change to a 3 – tiered co-pay structure. This could impact utilization by type of drug and average discounts. It is assumed the contractor will be able to adjust a) per unit expenses and b) guaranteed discounts at this time through the change order process. Can the government verify this assumption for both a) and b)?

Response 220. While TMA would not expect implementation of a three tier co-pay to result in any change to the offeror's network agreements, in the unlikely event a change would be required, remedies within the contract provide for contractual relief.

Question 221. Changes to the mail order pharmacy benefit changing the relationship between the retail and mail order benefits will impact the contractor by changing utilization by type of drug and average discounts. If the government changes the relationship of benefits (such as copays to emphasize mail order even more) between these two programs will the contractor be able to adjust a) per unit expenses and b) guaranteed discounts? If only the mail order benefits are changed will the contractor be able to adjust a) per unit expenses and b) guaranteed discounts?

Response 221. It is not anticipated that the TRICARE Mail Order Pharmacy will have a different co-pay structure than retail, only that the co-pay for TMOP grants a 90 day fill

versus a 30 day fill for retail. In the unlikely event a change would be required, remedies within the contract provide for contractual relief.

Question 222. In your response to question 106 you state, " The ICN will be included in the file sent to the Contractor by PDTS that identifies the TEDs submitted for payment to TMA."

a. How will this file be delivered?
b. What data elements will be included on the file?

Response 222. a. The file will be delivered through a secure socket connection using VPN technology.

b. All data elements submitted on the original TED for payment will be transferred to the Contractor. The process for the transfer and file production will be discussed during the implementation phase of the contract.

Question 223. In the Government's response to questions 146 they state that they will provide the Select Rx software and provide training at the Governments expense. For phase-in scheduling and staffing considerations please indicate when, during the phase-in period, the Government will provide this software and train the contractor's staff. Will training occur at the contractor's place of business or some other location? What is the length of time needed for training?

Response 223. a. The software will be provided within 30 calendar days after award.

b. Training will occur at the Contractor's place of business

c. Training varies from 1-2 days depending upon the scope of the user's responsibilities. For example, for viewing only for the Customer Service area, training would take one day while for use in the "intervention" area where PAs, overrides, etc are being performed by technicians and pharmacists the training would take two days.

Question 224. In an attempt to clarify what was asked in question 148 the following is submitted. If the contractor displaced 20 utilizers who each used the pharmacy once during a 12-month period, would this be viewed as having a more negative impact than displacing 5 utilizers who each used the pharmacy 24 times during a 12-month period?

Response 224. The Government will look primarily at the dispensing locations and the population affected by the loss of those locations. Locations with higher volume usage, not included in the network may impact the risk rating assessed to the factor.

Question 225. In your response to question 123 (related to C.8.1) you state, "This requirement has changed and is no longer applicable. It will be removed via amendment."

a. We are assuming PDTS will be determining if the beneficiary is TRICARE eligible or dual eligible and will be returning something to the contractor indicating such. Is this assumption correct?

b. Will this determination be made at point of sale?

c. If not, when will it be made?

d. How will the determination be returned to the contractor?

Response 225. a. Eligibility will be determined by DEERS and an eligibility response will be returned to the contractor through PDTS.

b. Yes.

c. At Point of Sale.

d. Via NCPDP 5.1 transaction in accordance with the PDTS ICD at Section J, Attachment 4.

Question 226. G.1.3.1 references a format provided for the Pharmacy Voucher/Bank Reconciliation Report. We cannot locate this format. Could you please provide directions to view the format for this report?

Response 226. We apologize for the inconvenience. A sample has been included via an upcoming amendment at Section J, Attachment 14, Figure 2.

Question 227. G.1.1.4 states PDTS will submit TED records to TMA daily. Should there be a requirement for the TRRx then to process payments each business day or will PDTS send blank records to TMA on days the TRRx contractor elects not to process payments if they chose to process less than daily?

Response 227. Following contract award, TMA will work with the contractor to establish a payment schedule to pay network pharmacies or beneficiaries in accordance with the contractor's normal operating procedures and its network agreements. After the first 20 days, TMA will issue administrative fee payments to the contractor on a daily basis for accepted TED records.

Question 228. Will the check date be the same date the TRRx receives the authorization from TMA, CRM to release payments? This requirement is in TRICARE Operations Manual Chapter 3, Section 6. If not, what date should be put on the checks?

Response 228. The TOM does not apply. Checks should be dated with the date of issuance.

Question 229. G.1.1.5.1 describes the contents of an electronic file to be transmitted 24 hours after authorization is received from TMA, CRM. Will this be sent via Connect:Direct, as an Excel spread sheet or by some other method?

Response 229. Submitting the data via Connect:Direct is the preferred method, however, TMA will work with the contractor following award to determine a mutually satisfactory method.

Question 230. G.1.1.5.3 indicates "The contractor shall require the bank to transmit directly to TMA a listing of all payments clearing the account". Is this file to be sent via NDM, Connect:Direct or by some other means? If the bank submits invalid data to TMA, what is the process for resolving this data? If a contractor receives an electronic file of payments clearing an account from the bank, will it be possible for the contractor to forward the file to TMA?

Response 230. This file will not be accepted from the contractor, it must be sent directly from the bank. It is meant as a control on the bank draws as well as the contractor's check processing. The file may be sent via Connect:Direct but this is open for alternative suggestions as long as TMA systems are able to read it.

Question 231. The RFP makes no reference to requirements for IRS withholding. Should this be a requirement of this RFP?

Response 231. TMA is unsure of the intent of the question. An offeror's business practices should comply with federal, state and local laws and regulations, but federal income tax withholding is not a specific requirement of the solicitation. If further clarification is required, please re-state the question.

Question 232. In the response to question 12 the government indicates there will be no conversion of pharmacy paid claim history files. Will the out-going contractor be responsible for the processing of adjustments to all claims they processed indefinitely or does a 6 year limitation apply? What will happen if a current MCS contractor is no longer in business after the next round of contract awards and an adjustment is required on a claim they processed?

Response 232. The Outgoing contractor is responsible for completion, within the time-periods specified, of all issues related to claims processed by them. The time limits set on appeal of a determination correspond to this requirement and are specified below as excerpted from the Managed Care Support Contractor Operations Manual, applicable to the Managed Care Support contracts:

> OPM Chapter 1, Section 8, Para. 5.3.9 Final Processing of Outgoing Contractor
>
> The Outgoing contractor shall:
>
> - Process all claims and adjustments identified by the 90th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery.

- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal/grievance cases which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

Question 233. G.1.1.7 states the network pharmacy payments will be accumulated until the payment date is reached based on the payment agreements with the network pharmacy. Since PDTS will transmit TED vouchers daily, can the payments be issued less frequently so long as the checks issued can be balanced to an accumulation of approved vouchers?

Response 233. Yes. Payments to network pharmacies may be issued in accordance with the contractors normal operating procedures. TMA will work with the contractor after award to establish payment schedules.

Question 234. G.1.2.3 says the appropriate CLIN is forwarded to PDTS for application in the voucher detail. What is the TED data element name or locator number for this data element?

Response 234. PDTS is responsible for submitting the TED records. The contractor must ensure the appropriate CLIN is provided to PDTS, in accordance with the PDTS ICD, at Section J, Attachment 4, so that the TED is correctly populated.

Question 235. Are the 24 timeframes in G.1.2.5 including weekends and holidays? Will notification be in addition to the return of the entire voucher for other possible types of errors for correction?

Response 235. The 24 hour timeframe refers to when cycles are processed which may include weekends and holidays. If this notification is delayed by a government entity (TMA, PDTS), the time periods for corrections will start from the date of receipt at the contractor. **Notification of CRM approval is sent separately from the error notifications and will only be done on federal workdays even if the cycles were processed on weekends.**

Question 236. G.1.2.5.4 states the processed to completion date on the TED record shall reflect the date the prescription was dispensed. We agree this makes sense for network pharmacy claims but not for beneficiary submitted paper claims. What date should be used for paper claims? If the same rule must hold for paper claims, this will cause a TED edit error (2-015-01R) because the filing date will be greater than the processed to completion date. This will also cause an anomaly in calculating paper claim processing timeliness. For adjustment claims, when an adjustment is identified after the 10 day hold or for paper claim submissions, what date should be reflected in the processed to completion date on the TED record to prevent this edit?

Response 236. For both initial and adjustment paper claims the Date the TED Record Processed to Completion as defined in the TRICARE Systems Manual should be used for the processed to completion date. This is the date the contractor processed the claim/treatment encounter data to completion. This is when all services and supplies on the claim have been adjudicated, payment has been determined, deductible has been applied, checks and EOBs have been prepared for mailing, and payment/deductible/denial has been posted to history and the TED record(s). This date does not change for resubmissions unless previously coded in error. This field should also be used for electronic claim adjustments made after the 10 day hold.

Question 237. We understand the need to hold TED vouchers for 10 days for network point of sale pharmacy claims, but doing this for beneficiary submitted paper claims seems to run counter to providing better customer service and timely payment. Would the government consider using some identifier already existing on the TED record, such as claim form type or assignment of benefits, to exempt paper claim submissions from this 10 day hold?

Response 237. Yes. The Government will not hold paper claim transactions received from the contractor for the 10 day period. These claims will be converted to TED records and transmitted to TMA with the next daily TED submittal.

Question 238. Are checks for amounts less than $1 to be mailed or should they be suppressed as required in other TRICARE contracts? If so, how will that be reported on the Pharmacy Voucher/bank Reconciliation Report?

Response 238. Checks for less than $1 should not be mailed. For reporting purposes, the total amount of these checks should be added as a separate line to the Reconciliation Report indicating transactions that were not processed as TEDS (the void or staledate for less than $1) due to the small dollar amounts. We will be reviewing the format of this report for some additional information fields.

Question 239. What data exchange is planned for the contractor to pass PDTS TED corrections? This section states PDTS will create a TED for each prescription filled and for each Prior Authorization and Medical Necessity determination. In the event a Prior Authorization and Medical Necessity determination is required, will PDTS be creating two TED records for the prescription, one for the fill and one for the Prior Authorization or Medical Necessity determination?

Response 239. Data exchanges between the contractor and PDTS will be in accordance with the PDTS ICD at Section J, Attachment 4. Where Prior Authorizations or Medical Necessity reviews are required, a TED will be generated for those as well as for the dispensed prescription. Payment of the administrative fee for both transactions will be based on the TED record.

Question 240. G.2.2 states PDTS will assign the ICN. How will this be done for paper claim submissions that will be received and controlled by the contractor?

Response 240. In the same manner. Following receipt of the prescription data from the contractor, PDTS will create the TED record and generate the ICN.

Question 241. Please define the control number referenced in G.1.1.4, G.1.1.5.1 and G.1.1.5.1.7. If multiple process to completion dates are submitted for approval to make payments, will there be one authorization code?

Response 241. This control number is meant to identify the TED record headers included in the payments being made on a given day. In the case of retail pharmacy, where the payment may only be issued every two weeks, monthly, etc., the TED records will be submitted every day to show the claims processed. Then, when the payment is due, a request must be sent to TMA to release those payments. The TED record headers involved must add up to the amount of the payments being made. And, all payments for that day will be identified with the control number.

Question 242. The Interface Control Document page 21 states PDTS will make only one query each day for each unique patient ID received. This makes sense for point of sale claims where the date of service is always the date of query but we do not understand how this will be done for paper claim submissions when the date of service will never be the current date. Would the government provide detail on how they expect this to happen for beneficiary submitted paper claims? This reference also uses the term pharmacy type. Would the government please define this usage in this incidence?

Response 242. You are correct. Paper claims may require more than one DEERS query if the claim is submitted with multiple prescriptions. Since TRICARE eligibility is based on the date of service, each prescription must be queried to determine eligibility at the time the prescription was filled. Pharmacy type on Page 21 of the ICD refers to retail, mail, or direct care. Patient eligibly, a yes/no response, is only one piece of the pie. Some beneficiaries can only get direct care, others mail and direct care - etc. For example, if a retail claim is submitted and the eligibility inquiry from DEERS indicates TRICARE eligibility, the patient category code may indicate that the beneficiary is only eligible for care through the direct care system. Therefore, in this particular case, the beneficiary is not eligible for TRICARE through the retail pharmacy.

Question 243. Will the government require the Miscellaneous Receipts and Small adjustments Report to be filed by the contractor?

Response 243. No.

Question 244. Will the government define any specific procedures for processing stale-dated, voided, or returned checks or EFTs?

Response 244. No. The contractor should process these in accordance with commercial practice and state law.

Question 245. As a follow up to the government's answer to question 120, will the TED cycle transmission contain a date for the TMA run date as exists today on the HCSR, which defines the time TMA ran the vouchers and batches on the cycle? Will the TED cycle as received by the contractor also now have the PDTS run date as well as the TMA run date? We believe the PDTS run date will be required for reporting contractor performance against the 20 and 40 day TED correction standards.

Response 245. TED data element TMA Batch/Voucher Processing Date corresponds to the HCSR element and defines the date the batch/voucher was processed by TMA. The PDTS run date will be included as a data element on the TED submission duplicate file that is provided to the Contractor as a duplicate of the file sent to TMA for payment.

Question 246. Reference the response to Question #102 states: "File structure and media format will be determined upon contract implementation."
Implementation seems a bit late for this. Should the response really be "upon contract award"?

Response 246. Yes, you are correct.

Question 247. The response to Questions 107, 126 and 134 is "TBD." Does the government intend to respond to these questions prior to the proposal submission date and issue an amendment if appropriate?

Response 247. Yes, answers are forthcoming soon.

Question 248. In response to Question 122 regarding a beneficiary's urgent need for a prescription to be dispensed and the presence on PDTS of an incorrect OHI indicator for Prescription Drugs, the government indicates in Response 122 (a) that on a case basis, beneficiaries may obtain an override for specific circumstances.

a. In this example, would the Pharmacist contact the TRRx Pharmacy Help Desk who in turn would contact PDTS Customer Service for an override?

b. If no, what would be the correct procedure to follow?

Response 248. a. Yes.

b. Not applicable.

Question 249. The response to Question #127 indicates an addition made by amendment. Several other answers indicate changes via amendment, which as of April 12, 2003 has not been released. Will the government consider extending the deadline for receipt of questions to one day after the amendment is released?

Response 249. At the discretion of the Contracting Officer, an additional 5 working days may be considered for the submission of questions after issuance of an amendment.

Question 250. Reference PDTS ICD. What is the correction transaction and record format to use for Claims Adjustments?

Response 250. The format and content of both transactions are well documented in the PDTS ICD which conform to NCPDP 5.1 requirements.